JACK O'CONNELL
State Superintendent of Public Instruction

CALIFORNIA DEPARTMENT OF EDUCATION
1430 N Street
P.O. Box 944272
Sacramento, CA
94244-2720

Child and Adult Care Food Program

Claim For Reimbursement Instructions

October 2003

October 2003

*

Child and Adult Care Food Program

Claim for Reimbursement Instructions

*

Child Nutrition Fiscal Services
FISCAL AND ADMINISTRATIVE SERVICES DIVISION

CALIFORNIA DEPARTMENT OF EDUCATION

This booklet was produced by the Child Nutrition Fiscal Services (CNFS) unit of the Fiscal & Administrative Services Division (FASD), California Department of Education (mailing address: P.O. Box 587, Sacramento, CA 95812-0587). Comments regarding the content of this booklet should be directed to Phyllis Savage, Manager, CNFS, Fiscal And Administrative Services Division at (916) 322-8326. For clarification on instructions, call (916) 322-8312.

2003

Table of Contents

Introduction

The Child and Adult Care Food Program plays a vital role in improving the quality of day care and making it more affordable for many low-income families. Each day, 2.6 million children receive nutritious meals and snacks through this federally funded program. This program also provides meals and snacks to 74,000 adults who receive care in nonresidential adult day care centers. The Child and Adult Care Food Program reaches even further to provide meals to children residing in homeless shelters, and snacks and suppers to youths participating in eligible afterschool care programs. California's Child and Adult Care Food Program is administered by the California Department of Education.

Once approved to participate in the Child and Adult Care Food Program, each sponsor must submit a monthly Claim for Reimbursement to receive payment for meals served. Instructions and sample worksheets are included in this booklet to assist you in completing the claim form. If you have any questions related to claim completion or payments, please contact the Child Nutrition Fiscal Services Unit at (916) 322-8312.

For specific details related to allowable operating and administrative costs, program income, and meals, please refer to the Child Care Centers or Day Care Home Sponsors Administrative Manuals or contact your field consultant.

Terminology and Definitions

Actual Data: Reportable data for which the sponsor has supporting documentation at the time of claim submission. All data reported on the claim for reimbursement must be actual data.

Adjusted Claim: Any claim, subsequent to the original claim, that the sponsor submits with any changes of data. Claims subsequent to the original that are required by the State as a result of an audit or administrative review are excluded from this category (see "Audited Claim").

Annual Participation Statement (APS): The annual renewal document sent to sponsors by NSD requesting program participation information.

Audited Claim: Corrections or changes made to a previously submitted claim as required by the State as a result of the findings of an audit.

CAP: Corrective Action Plan. The form used to request a one-time only exception that must include a detailed explanation of the problem(s) contributing to the lateness, and actions being taken to avoid future late claim submissions (see Appendix A-9).

Cash Advance: Payments made in advance of the claim reimbursements to improve cash flow.

Claim for Reimbursement: A child nutrition request for reimbursement submitted by a participating agency (sponsor) to the State for payment (see Appendix A-10 through A-13 for claim samples).

Claim Month: The month for which data reported on the claim was collected.

Claim Submission Deadline: The final date that a claim may be accepted for consideration of payment; that is, the 20th day of the second month after the claim month. The final date must be officially postmarked by the United States Post Office (see Appendix A-1 for Claim Submission Deadlines).

CNFS: Child Nutrition Fiscal Services in the California Department of Education. The Child Nutrition Fiscal Services Unit is responsible for processing the child nutrition claims for reimbursement.

Corrected Claim: A claim resubmitted by the sponsor after it was returned by the State for corrections. A corrected claim is also a claim produced when the State advises the sponsor via telephone that a claim must be corrected before it can be processed. All changes to claims must be made by the sponsor and certified by an original signature. Corrected claims are annotated by the preparer as such on the top/center of the claim in bold print.

CRE: Coordinated Review Effort. Program regulations require that each Child and Adult Care Food Program Sponsor be reviewed at least every three years to determine compliance with performance and regulatory standards. This review is administered by the Nutrition Services Division, Field Services Unit.

FASD: Fiscal and Administrative Services Division in the California Department of Education.

NSD: The Nutrition Services Division in the California Department of Education, formerly the Child Nutrition and Food Distribution Division.

Original Claim: The first claim submitted by a sponsor to the State for a particular month.

Postmark: The postmark must be an official United States Post Office postmark. The postmark will determine if a claim has been submitted within the claim submission deadline.

Site Change Request: A request submitted to NSD to change program participation or to add/drop sites. You may contact NSD for a Site Change Request.

Sponsor: An agency/district approved for and participating in child nutrition programs.

State Agency: The state educational agency designated by the Governor or other appropriate executive or legislative authority of the State and approved by the United States Department of Agriculture to administer nutrition programs within the State. This is currently the California Department of Education.

USDA: The United States Department of Agriculture, Food and Nutrition Services.

Zero Claim: Claim submitted to CNFS for a month of non-operation by the CACFP Sponsor.

Claim Submission Deadline Policy

To be entitled to reimbursement, each sponsor must submit a monthly claim for reimbursement (and one photocopy), which must include data in sufficient detail to justify the reimbursement claimed. Such data must include, at a minimum, the number of free, reduced price and paid meals served; and an authorized agency/district official must sign the claim. All claims submitted must include an agreement number and an original signature to be considered a valid claim. Faxed claims will not be accepted.

All claims (original and adjusted) must be postmarked by the twentieth (20th) day of the second month following the month claimed in order to be considered for payment (see Appendix A-1 for claim submission deadlines). For example, a July claim must be postmarked by September 20th. If the twentieth day falls on a holiday or weekend, the deadline will be the next working day. Claims submitted after this date cannot be processed, except as described on page 5, "Late Claims". Mail claims to:

California Department of Education
Child Nutrition Fiscal Services
P.O. Box 587
Sacramento, CA 95812-0587

Corrected claims must be returned to Child Nutrition Fiscal Services (CNFS) no later than the tenth (10th) day of the third month following the month claimed in order to be considered for payment. For example, a July claim correction must be received by October 10th. The submission deadline for audited claims is established by the State on a case-by-case basis.

NOTE: We do not recommend the use of certified mail for the submission of claims to our office, as this could delay the processing of your claim. For verification of the receipt of your claim, enclose a self-addressed stamped postcard noting your agency name, agreement number, claim month, and if it is an original or adjusted claim. Enclose this postcard with your claim and submit it to our office via regular U. S. Mail, and it will be signed, dated and returned to you. If certified mail is used, mail must be addressed to the street address below, not the P.O. Box. ***CDE cannot be held responsible for certified mail that is misdirected by the U. S. Postal Service.***

Sponsors are not encouraged to personally deliver claims. However, if claims are delivered personally, they must be delivered to:

California Department of Education
Child Nutrition Fiscal Services
1430 N Street, Room 2213
Sacramento, CA 95814

To be valid, personally delivered claims must be date stamped at the mail desk.

As a courtesy, approximately 50 days after the end of a claim month, CNFS sends a "Notice of Delinquent Claim" to each sponsor from whom we have not received a claim.

Late Claims

There are two types of adjusted claims that can be submitted after the claim submission deadline:

1. Changes to meal data that result in no increase in reimbursement.

2. Downward adjusted claims. An adjusted claim must be submitted to correct an error that resulted in the sponsor being overpaid.

Adjusted claims that are received after the claim submission deadline and result in an increase in reimbursement cannot be processed. Upward adjusted claims received after the deadline for submission will automatically be rejected for payment and will be returned to the sponsor unless the reason(s) for a late submission meets one or more of the criteria described below.

There are three instances in which a late claim may be considered for payment:

1. Audit/ Coordinated Review Effort (CRE) Adjustment

   Adjusted claims submitted to correct an error(s) discovered on an earlier claim by an independent audit or a review. The sponsor must explain the circumstances surrounding the discovery of the error(s) and must transmit a copy of the audit or review report with the adjusted claim. **NOTE:** Unless the error is noted in an independent audit or review report, additional payment cannot be approved.

2. One-Time Exception

   The State Agency may grant a one-time exception whenever a sponsor has NOT been granted an exception during the previous 36 months. To receive a one-time exception, a sponsor must submit an acceptable Corrective Action Plan (CAP) to the State Agency (see Appendix A-9 for CAP outline). Your CAP must include:

   - A detailed explanation of the problem(s) contributing to the lateness.
   - Actions being taken to avoid future late claim submissions.
   - A statement to the effect that the sponsor understands that if this exception request is granted, the one-time exception will be made by NSD based on the acceptability of the CAP.
   - Signature of the claim preparer and an authorized district/agency official. Authorized officials must be employees of the district/agency.

3. Late claims approvable only by USDA

   A late claim may be approved for payment by USDA if it meets one of the four exception criteria listed below:

   A. Major breakdowns in mechanical processing accompanied by inability to manually process the data. For example, a sponsor experienced major data processing failures.

B. Natural catastrophes coupled with the sponsor's inability to manually process the data. For example, floods or earthquakes destroying records, equipment or facilities.

C. Unusual postal delays that are verified by a postal receipt or other specific verification from the postal service.

D. Death or severe illness of key staff in situations where it is not possible to assume the sponsor could have utilized backup staff.

The request for a USDA exception must include the claim and a letter, which demonstrates that the reason for missing the claim submission deadline was clearly beyond your control. The letter must explain in detail the extenuating circumstances which made it impossible to meet the deadline, and that the deadline was not missed because of negligence, oversight or workload backlog. Requests for a USDA exception must be submitted via CNFS. Requests deemed to meet USDA's criteria will be forwarded by CNFS for approval. Please submit requests to:

California Department of Education
Child Nutrition Fiscal Services
P.O. Box 587
Sacramento, CA 95812-0587

Address Changes and Labels

You have been provided with enough labels to submit claim for reimbursement forms for one year. You will be provided with a new supply each year. Upon receipt, inspect the labels for accuracy. If corrections are needed, attach a label to district/agency letterhead, type or print the correct information, and submit to:

California Department of Education
Nutrition Services Division
Resources and Information Management Unit
560 J Street, Suite 270
Sacramento, CA 95814-2342

If your address changes, you must contact the IRS at (877) 829-5500, or fax (513) 263-3756. The IRS will update your information via telephone and fax you a revised IRS Determination Letter the same day.

If you prefer to contact the IRS via the mail, the address is:

Internal Revenue Service
TEGE Division, Suite 400
P.O. Box 2508
Cincinnati, OH 45201

Once you have the IRS Determination Letter, you may fax it to the Resources and Information Management Unit (RIM) of the Nutrition Services Division at 1-800-333-5775, or mail it to the above California Department of Education address.

Reimbursement Instructions

REIMBURSEMENT CLAIMING PROCEDURES –
Child and Adult Care Food Program – Fixed Percentage Claiming Method

Enter the program information for only one **claim month** in Items 1 through 10. This information should cover only Program operations for that month except if the first or last month of Program operations in any fiscal year contains 10 operating days or less, such month may be added to the Claim for Reimbursement for the appropriate adjacent month; however, Claims for Reimbursement may not combine operations occurring in two fiscal years.

All data submitted on the claim for reimbursement must be actual data. CDE reserves the right to hold a claim for further investigation if claiming patterns suggest estimated data is being submitted.

An error or omission on any of the following items may cause the claim to be rejected, resulting in delays in processing your claim and the receipt of reimbursement. See Appendix A-10 for a sample of the "Claim for Reimbursement-Child and Adult Care Food Program, Fixed Percentage Claiming Method" (CACFP-F).

Item 1. **Agreement Number, Name and Address** - Place a preprinted label in the space provided on the original claim form. The labels provided by CDE are for use on the claim for reimbursement only. If you run out of labels, type or print your agreement number, name and address in the space provided. Name and/or address changes must be approved by the NSD prior to use on the claim form.

Item 2. **Month/Year** - Enter the two-digit month and four-digit year the claim covers, not the month the claim was prepared. The month and year must be reported numerically as shown in the following examples:

December 2003 = 1 | 2 | 2 | 0 | 0 | 3 January 2004 = 0 | 1 | 2 | 0 | 0 | 4

Item 3. **Claim Type** – Mark the appropriate box. One box must be checked.

A. **Original Claim** refers to the first claim submitted to CNFS for a claim month. Actual data must be reported. No estimates or projections will be accepted. An original claim returned to you by CNFS for correction is still an original claim when resubmitted. Please indicate this by writing the word "correction" on the top of the corrected claim form.

B. **Adjusted Claim** refers to any claim submitted subsequent to the original claim with verified changes to previously reported data. The figures on an adjusted claim replace the originally reported figures. You must complete the entire claim to reflect both data that has changed and data that has remained as originally reported. If previously reported data needs to be deleted, please indicate this by placing a zero in the appropriate space. In addition, complete items 1, 2, 3B and the certification section.

Note: A sponsor may submit only two adjusted claims per claim month. Adjusted Claims that reflect increases in meals served must be submitted by the claim submission deadline.

C. **No Reimbursement will be Claimed this Month (Zero Claim)** refers to those months in which your program is inactive and no reimbursement is being claimed. Completion of items 1, 2, 3C and the certification block is required. A "Zero Claim" must be completed and submitted for each inactive month. Sponsors temporarily closed for the summer or for several consecutive months may submit zero claims in advance.

Item 4. **DO NOT COMPLETE.** This item is for CDE use only.

Item 5. **DO NOT COMPLETE.** This item is for CDE use only.

Item 6. **Number of Approved Sites that Operated this Month** - Enter the number of approved active sites for the claim month. To be considered active, a site must serve at least one meal during the claim month. The number of sites claimed cannot exceed the number of sites approved by NSD. All site additions/deletions must be approved by submitting a "Site Change Request Form" prior to claiming reimbursement.

Item 7. **Program Enrollment** - Complete this section on the October claim **or** the first month of operation in the fiscal year (October through September) using your participation eligibility roster for each center for that month. CNFS will calculate a percentage for each eligibility category based upon the enrollment eligibility data. The percentages established will become the fixed percentage for the fiscal year.

You must report new enrollment data during a fiscal year when (1) you add an approved site, (2) the average daily participation exceeds previously reported enrollment, and/or (3) a reporting error has been identified.

When adding a new site during the fiscal year, you are required to combine the enrollment data from the new site with your previously reported enrollment figures.

You may report new enrollment data any time it is deemed by your agency to be financially advantageous.

Number of participants eligible for free meals - Enter the number of participants with current approved eligibility applications on file for free meals.

Number of participants eligible for reduced meals - Enter the number of participants with current approved eligibility applications on file for reduced price meals.

Number of participants eligible for base rate meals - Enter the number of participants **not** approved for free or reduced price meals.

Total - Enter the total number of enrolled participants in the program during the claim month. Include all participants with enrollment or eligibility forms on file who ate at least one meal during the month. The total enrollment must equal the sum of eligible free, reduced price and base rate participants.

Item 8. **Number of Days Program Meals were Served this Month** - Enter the number of days program meals were served during the claim month. If reporting as a sponsoring organization, enter the highest number of days of service by any one site.

Item 9. **Average Daily Participation** - Using daily meal count records for all approved sites, total the number of participants who consumed at least one meal or supplement for the claim month and divide by the highest number of days food was served.

*Example: 863 participants divided by 21 days equal 41.1. Round **up** to 42. For this example, the figure 42 would be entered in item 9.*

Always round the average daily participation up to the nearest whole number.

Item 10. **Meals Served** - Report the total number of documented meals served at each center during the calendar month by meal type (breakfast, lunch, supper, and supplements). This reporting method requires a head count at each meal service.

Certification - Before submitting your claim, be sure to complete this section. Enter the printed name and telephone number of the person preparing the claim and the preparation date. An original signature of an authorized official is required. In addition, print the name and title of the authorized official. The signature of the authorized representative must be in ink. Only original signatures will be accepted.

YOUR CLAIM WILL BE RETURNED FOR CORRECTION IF IT IS NOT PROPERLY COMPLETED. PLACE AN ORIGINAL SIGNATURE ON THE CLAIM BEFORE MAILING TO AVOID DELAYS IN YOUR REIMBURSEMENT. The agency authorized official signing the claim is responsible for reviewing and analyzing meal counts before submission to ensure accuracy.

SPECIAL NOTE: An adjusted claim for reimbursement completely voids all previously submitted data for the same claiming period. Therefore, when submitting an adjustment, you must report all data whether there has been a change or not.

If you choose to manually determine the federal and state reimbursement earned for the month, complete the "Monthly Reimbursement Calculation Worksheet", Appendix A-5. Do not submit the worksheet with your claim; it is for your reference only.

REIMBURSEMENT CLAIMNG PROCEDURES –
Child and Adult Care Food Program – Actual Count Claiming Method

Enter the program information for only one **claim month** in Items 1 through 10. This information should cover only Program operations for that month except if the first or last month of Program operations in any fiscal year contains 10 operating days or less, such month may be added to the Claim for Reimbursement for the appropriate adjacent month; however, Claims for Reimbursement may not combine operations occurring in two fiscal years.

All data submitted on the claim for reimbursement must be actual data. CDE reserves the right to hold a claim for further investigation if claiming patterns suggest estimated data is being submitted.

An error or omission on any of the following items may cause the claim to be rejected, resulting in delays in processing your claim and the receipt of reimbursement. See Appendix A-11 for a sample of the "Claim for Reimbursement-Child and Adult Care Food Program, Actual Count Claiming Method" (CACFP-A).

Item 1. **Agreement Number, Name and Address -** Place a preprinted label in the space provided on the original claim form. The labels provided by CDE are for use on the claim for reimbursement only. If you run out of labels, type or print your agreement number, name and address in the space provided. Name and/or address changes must be approved by the NSD prior to use on the claim form.

Item 2. **Month/Year -** Enter the two-digit month and four-digit year the claim covers, not the month the claim was prepared. The month and year must be reported numerically as shown in the following examples:

December 2003 = 1 | 2 | 2 | 0 | 0 | 3 January 2004 = 0 | 1 | 2 | 0 | 0 | 4

Item 3. **Claim Type** - Mark the appropriate box. One box must be checked.

A. Original Claim refers to the first claim submitted to CNFS for a claim month. Actual data must be reported. No estimates or projections can be accepted. An original claim returned by CNFS for correction is still an original claim when resubmitted. Please indicate this by writing the word "correction" on the top of the corrected claim form.

B. Adjusted Claim refers to any claim submitted subsequent to the original claim with verified changes to previously reported data. The figures on an adjusted claim replace the originally reported figures. You must complete the entire claim to reflect both data that has changed and data that has remained as originally reported. If previously reported data needs to be deleted, please indicate this by placing a zero in the appropriate space. In addition, complete items 1,2,3B and the certification section

Note: A sponsor may submit only two adjusted claims per claim month. Adjusted Claims that reflect increases in meals served must be submitted by the claim submission deadline.

C. <u>No Reimbursement will be Claimed this Month (Zero Claim)</u> refers to those months in which your program is inactive and no reimbursement is being claimed. Completion of items 1, 2, 3C and the certification block is required. A "Zero Claim" must be completed and submitted for each inactive month. Sponsors temporarily closed for the summer or for several consecutive months may submit zero claims in advance.

Item 4. **DO NOT COMPLETE.** This item is for CDE use only.

Item 5. **DO NOT COMPLETE.** This item is for CDE use only.

Item 6. **<u>Number of Approved Sites that Operated this Month</u>** - Enter the number of approved active sites for the claim month. To be considered active, a site must serve at least one meal during the claim month. The number of sites claimed cannot exceed the number of sites approved by NSD. All site additions/deletions must be approved by submitting a "Site Change Request Form" prior to claiming reimbursement.

Item 7. **<u>Program Enrollment</u>** - Complete this section monthly for each eligibility category. The figures entered are to match the participant eligibility roster for the month.

<u>Number of participants eligible for free meals</u> - Enter the number of participants with current approved eligibility applications on file for free meals. These applications should be counted each month.

<u>Number of participants eligible for reduced meals</u> - Enter the number of participants with current approved eligibility applications on file for reduced price meals. These applications should be counted each month.

<u>Number of participants eligible for base rate meals</u> - Enter the number of participants **not** approved for free or reduced price meals. This count should be made each month.

<u>Total</u> - Enter the total number of enrolled participants in the program during the claim month. Include all participants with enrollment or eligibility forms on file who ate at least one meal during the month. The total enrollment must equal the sum of eligible free, reduced price and base rate participants.

Item 8. **<u>Number of Days Program Meals were Served this Month</u>** - Enter the number of days program meals were served during the claim month. If reporting as a sponsoring organization, enter the highest number of days of service by any one site.

Item 9. **Average Daily Participation** - Using daily meal count records for all approved sites, total the number of participants who consumed at least one meal or supplement for the claim month and divide by the highest number of days food was served.

*Example: 863 participants divided by 21 days equal 41.1. Round **up** to 42. For this example, the figure 42 would be entered in item 9.*

Always round the average daily participation up to the nearest whole number.

Item 10. **Meals Served** - Enter the number of documented meals served during the month by approved eligibility category and meal type. The total meals for each meal type must equal the sum of the free, reduced price and base meals. Meals claimed using the Actual Count Claiming Method must be documented by daily meal count reports, which correctly identify each participant by name, eligibility category and meal type received.

Certification - Before submitting your claim, be sure to complete this section. Enter the printed name and telephone number of the person preparing the claim and the preparation date. An original signature of an authorized official is required. In addition, print the name and title of the authorized official. The signature of the authorized representative must be in ink. Only original signatures will be accepted.

YOUR CLAIM WILL BE RETURNED FOR CORRECTION IF IT IS NOT PROPERLY COMPLETED. PLACE AN ORIGINAL SIGNATURE ON THE CLAIM BEFORE MAILING TO AVOID DELAYS IN YOUR REIMBURSEMENT. The agency authorized official signing the claim is responsible for reviewing and analyzing meal counts before submission to ensure accuracy.

SPECIAL NOTE: An adjusted claim for reimbursement completely voids all previously submitted data for the same claiming period. Therefore, when submitting an adjustment, you must report all data whether there has been a change or not.

If you would like to determine the federal and state reimbursement earned for the month, complete the "Monthly Reimbursement Calculation Worksheet", Appendix A-6. Do not submit the worksheet with your claim; it is for your reference only.

REIMBURSEMENT CLAIMING PROCEDURES –

Child and Adult Care Food Program – Actual Count Claiming Method for Sponsors of Independent Centers

Enter the program information for only one **claim month** in Items 1 through 12. This information should cover only Program operations for that month except if the first or last month of Program operations in any fiscal year contains 10 operating days or less, such month may be added to the Claim for Reimbursement for the appropriate adjacent month; however, Claims for Reimbursement may not combine operations occurring in two fiscal years.

All data submitted on the claim for reimbursement must be actual data. CDE reserves the right to hold a claim for further investigation if claiming patterns suggest estimated data is being submitted.

An error or omission on any of the following items may cause the claim to be rejected, resulting in delays in processing your claim and the receipt of reimbursement. See Appendix A-12 for a sample of the "Claim for Reimbursement-Child and Adult Care Food Program Actual Count Claiming Method for Sponsors of Independent Centers" (CACFP-I).

Item 1. **Agreement Number, Name and Address** - Place a preprinted label in the space provided on the original claim form. The labels provided by CDE are for use on the claim for reimbursement only. If you run out of labels, type or print your agreement number, name and address in the space provided. Name and/or address changes must be approved by the NSD prior to use on the claim form.

Item 2. **Month/Year** - Enter the two-digit month and four-digit year the claim covers, not the month the claim, was prepared. The month and year must be reported numerically as shown in the following examples:

December 2003 = 1 | 2 | 2 | 0 | 0 | 3 January 2004 = 0 | 1 | 2 | 0 | 0 | 4

Item 3. **Claim Type** – Mark the appropriate box. One box must be checked.

A. Original Claim refers to the first claim submitted to CNFS for a claim month. Actual data must be reported. No estimates or projections will be accepted. An original claim returned to you by CNFS for correction is still an original claim when resubmitted. Please indicate this by writing the word "correction" on the top of the corrected claim form.

B. Adjusted Claim refers to any claim submitted subsequent to the original claim with verified changes to previously reported data. The figures on an adjusted claim replace the originally reported figures. You must complete the entire claim to reflect both data that has changed and data that has remained as originally reported. If previously reported data needs to be deleted, please indicate this by placing a zero in the appropriate space. In addition, complete items 1, 2, 3B and the certification section.

Note: A sponsor may submit only two adjusted claims per claim month. Adjusted Claims that reflect increases in meals served must be submitted by the claim submission deadline.

C. **No Reimbursement will be Claimed this Month (Zero Claim)** refers to those months in which your program is inactive and no reimbursement is being claimed. Completion of items 1, 2, 3C and the certification block is required. A "Zero Claim" must be completed and submitted for each inactive month. Sponsors temporarily closed for the summer or for several consecutive months may submit zero claims in advance.

Item 4. **DO NOT COMPLETE.** This item is for CDE use only.

Item 5. **DO NOT COMPLETE.** This item is for CDE use only.

Item 6. **Number of Approved Sites that Operated this Month** - Enter the number of approved active sites for the claim month. To be considered active, a site must serve at least one meal during the claim month. The number of sites claimed cannot exceed the number of sites approved by NSD. All site additions/deletions must be approved by submitting a "Site Change Request Form" prior to claiming reimbursement.

Item 7. **Program Enrollment** - Complete this section monthly for each eligibility category. The figures entered are to match the participant eligibility roster for the month.

Number of participants eligible for free meals - Enter the number of participants with current approved eligibility applications on file for free meals. These applications should be counted each month.

Number of participants eligible for reduced meals - Enter the number of participants with current approved eligibility applications on file for reduced price meals. These applications should be counted each month.

Number of participants eligible for base rate meals - Enter the number of participants **not** approved for free or reduced price meals. This count should be made each month.

Total - Enter the total number of enrolled participants in the program during the claim month. Include all participants with enrollment or eligibility forms on file who ate at least one meal during the month. The total enrollment must equal the sum of eligible free, reduced price and base rate participants.

Item 8. **Number of Days Program Meals were Served this Month** - Enter the number of days program meals were served during the claim month. If reporting as a sponsoring organization, enter the highest number of days of service by any one site.

Item 9. **Average Daily Participation** – Using daily meal count records for all approved sites, total the number of participants who consumed at least one meal or supplement for the claim month and divide by the highest number of days food was served.

*Example: 863 participants divided by 21 days equal 41.1. Round **up** to 42. For this example, the figure 42 would be entered in item 9.*

Always round the average daily participation up to the nearest whole number.

Item 10. **Meals Served** - Enter the number of documented meals served during the month by approved eligibility category and meal type. The total meals for each meal type must equal the sum of the free, reduced price and base meals. Meals claimed using the Actual Count Claiming Method must be documented by daily meal count reports, which correctly identify each participant by name, eligibility category and meal type received.

Item 11. **CCFP Administrative Expenses for this Month** – Report all allowable costs identified in your agency's administrative budget as approved expenses. (Refer to section 560 in the Child Care Centers Administrative Manual). Time-study reports for labor and proration formulas for other costs must be on file. Costs shared by CCFP and other funding sources must be prorated to determine the amount chargeable to CCFP. The amount reported must be based on the actual expenses, not on the approved administrative budget allocation nor the amount retained for administration. The reported amount may not be less than $1 and must be rounded to a whole dollar.

Item 12. **CCFP Administrative Income for this Month** – Report the amount of government monies (federal, state, and local, excluding CCFP federal and state reimbursement) restricted to food program costs received for the month, any other funding, and any cash donations specified for CCFP. Include reimbursement for an organization-wide audit in the month in which it is received.

Certification – Before submitting your claim, be sure to complete this section. Enter the printed name and telephone number of the person preparing the claim and the preparation date. An original signature of an authorized official is required. In addition, print the name and title of the authorized official. The signature of the authorized representative must be in ink. Only original signatures will be accepted.

YOUR CLAIM WILL BE RETURNED FOR CORRECTION IF IT IS NOT PROPERLY COMPLETED. PLACE AN ORIGINAL SIGNATURE ON THE CLAIM BEFORE MAILING TO AVOID DELAYS IN YOUR REIMBURSEMENT. The agency authorized official signing the claim is responsible for reviewing and analyzing meal counts before submission to ensure accuracy.

SPECIAL NOTE: An adjusted claim for reimbursement completely voids all previously submitted data for the same claiming period. Therefore, when submitting an adjustment, you must report all data whether there has been a change or not.

If you choose to manually determine the federal and state reimbursement earned for the month, complete the "Monthly Reimbursement Calculation Worksheet", Appendix A-7. Do not submit the worksheet with your claim; it is for your reference only.

REIMBURSEMENT CLAIMING PROCEDURES –
Child and Adult Care Food Program - Day Care Homes

Enter the program information for only one **claim month** in Items 1 through 12. This information should cover only Program operations for that month except if the first or last month of Program operations in any fiscal year contains 10 operating days or less, such month may be added to the Claim for Reimbursement for the appropriate adjacent month; however, Claims for Reimbursement may not combine operations occurring in two fiscal years.

All data submitted on the claim for reimbursement must be actual data. CDE reserves the right to hold a claim for further investigation if claiming patterns suggest estimated data is being submitted.

An error or omission on any of the following items may cause the claim to be rejected, resulting in delays in processing your claim and the receipt of reimbursement. See Appendix A-13 for a sample of the "Claim for Reimbursement-Child and Adult Care Food Program, Day Care Homes" (CACFP-T2).

Item 1. **Agreement Number, Name and Address** - Place a preprinted label in the space provided on the original claim form. The labels provided by CDE are for use on the claim for reimbursement only. If you run out of labels, type or print your agreement number, name and address in the space provided. Name and/or address changes must be approved by the NSD prior to use on the claim form.

Item 2. **Month/Year** - Enter the two-digit month and four-digit year the claim covers, not the month the claim was prepared. The month and year must be reported numerically as shown in the following examples:

December 2003 = 1 | 2 | 2 | 0 | 0 | 3 January 2004 = 0 | 1 | 2 | 0 | 0 | 4

Item 3. **Claim Type** – Mark the appropriate box. One box must be checked.

A. **Original Claim** refers to the first claim submitted to CNFS for a claim month. Actual data must be reported. No estimates or projections will be accepted. An original claim returned to you by CNFS for correction is still an original claim when resubmitted. Please indicate this by writing the word "correction" on the top of the corrected claim form.

B. **Adjusted Claim** refers to any claim submitted subsequent to the original claim with verified changes to previously reported data. The figures on an adjusted claim replace the originally reported figures. You must complete the entire claim to reflect both data that has changed and data that has remained as originally reported. If previously reported data needs to be deleted, please indicate this by placing a zero in the appropriate space. In addition, complete items 1, 2, 3B and the certification section.

Note: A sponsor may submit only two adjusted claims per claim month. Adjusted Claims that reflect increases in meals served must be submitted by the claim submission deadline.

C. **No Reimbursement Will be Claimed this Month (Zero Claim)** refers to those months in which your program is inactive and no reimbursement is being claimed. Completion of items 1, 2, 3C and the certification block is required. A "Zero Claim" must be completed and submitted for each inactive month. Sponsors temporarily closed for the summer or for several consecutive months may submit zero claims in advance. Do not leave spaces blank, put "0" in appropriate boxes.

Item 4. **DO NOT COMPLETE.** This item is for CDE use only.

Item 5. **DO NOT COMPLETE.** This item is for CDE use only.

Item 6. **Number of Days Program Meals were Served this Month** - Enter the number of days program meals were served during the claim month. If reporting as a sponsoring organization, enter the highest number of days of service by any one site.

Item 7. **Approved Sites that Operated this Month** - Enter the number of approved active sites by tiering category for the claim month. To be active, a site must serve at least one meal during the claim month. The number of sites claimed cannot exceed the number of sites approved by NSD. All site additions/deletions must be approved by submitting a "Site Change Request Form" prior to claiming reimbursement.

Item 8. **Average Daily Participation** - Using daily meal count records for all approvesites, total the number of participants who consumed at least one meal or supplement for the claim month and divide by the highest number of days food was served.

Enter the average daily participation separated by provider type, i.e., Tier I Homes, Tier II Homes and Tier II Mixed Homes. Sum across to calculate total average daily Participation (ADP).

*Example: 863 Tier I children divided by 21 days equals 41.1. Round **up** to 42. For this example, the figure 42 should be entered in item 8 Tier I. Tier I, Tier II, and Tier II Mixed ADP's should be added to calculate the Total Average Daily Participation.*

Always round the average daily participation up to the nearest whole number.

Item 9. **Program Enrollment** - Enter the total number of children by tiering category who consumed at least one meal during the claim month and who have an enrollment or eligibility form on file. Sum across to calculate total enrollment.

Item 10. **Meals Served** - Enter the total number of documented meals served during the claim month by tiering category and meal type. Sum across by meal type to calculate total meals served.

Item 11. **CCFP Administrative Expenses for this Month** - Report all allowable costs in your agency's administrative budget as expenses (Refer to section 562 in the Day Care Homes Administrative Manual). Costs shared by CACFP and other funding sources must be prorated to determine the amount chargeable to CACFP. Time-study reports for labor and proration formulas for other costs must be on file. The amount reported must be based on actual allowable expenses, not on the approved administrative budget or administrative reimbursement rates. The reported amount may not be less than $1 and must be rounded to the whole dollar.

Item 12. **CCFP Administrative Income for this Month** - Report the amount of State Meal reimbursement used for administrative expenses. (Refer to section 512 in the Day Care Homes Administrative Manual). Also, report the amount of government monies (federal, state, and local, excluding CACFP federal reimbursement) restricted to food program administrative costs, any other funding, and any cash donations specified for CACFP received for the claim month. Include reimbursement for an organization-wide audit in the month in which it is received. Funds borrowed from the sponsor's general fund to pay food service costs/expenses on a temporary basis must be documented and clearly identified as a loan to be replaced when reimbursement is received. This type of transaction is not income. In addition, do not report state meal reimbursement issued to providers. Documentation of use of state meal reimbursement must be retained for audit purposes.

Note: The CDE determines the amount of administrative costs used in the computation of federal administrative reimbursement by deducting the income reported in item 12 from the expenses reported in item 11.

Certification - Before submitting your claim, be sure to complete this section. Enter the printed name and telephone number of the person preparing the claim and the preparation date. An original signature of an authorized official is required. In addition, print the name and title of the authorized official. The signature of the authorized representative must be in ink. Only original signatures will be accepted.

YOUR CLAIM WILL BE RETURNED FOR CORRECTION IF IT IS NOT PROPERLY COMPLETED. PLACE AN ORIGINAL SIGNATURE ON THE CLAIM BEFORE MAILING TO AVOID DELAYS IN YOUR REIMBURSEMENT. The agency authorized official signing the claim is responsible for reviewing and analyzing meal counts before submission to ensure accuracy.

SPECIAL NOTE: An adjusted claim for reimbursement completely voids all previously submitted data for the same claiming period. Therefore, when submitting an adjustment, you must report all data whether there has been a change or not.

If you would like to determine the federal and state reimbursement earned for the month, complete the "Monthly Reimbursement Calculation Worksheet", Appendix A-8. Do not submit the worksheet with your claim; it is for your reference only.

Claim Corrections

CORRECTION vs. ADJUSTMENT

A claim resubmitted by the sponsor after it was returned by CNFS for corrections is a corrected claim. A corrected claim is also a claim produced when CNFS advises the sponsor via telephone that a claim must be corrected before it can be processed.

Corrected claims should not be confused with adjusted claims.

A claim will be returned for a correction if it is not properly completed. The following are examples of reasons why a claim would be returned for a correction:

1. Sites reported exceed approved sites.
2. Missing data.
3. Average daily participation exceeds enrollment.
4. Summations do not equal total.

A correction letter will be sent along with the returned claim outlining the errors and instructions for resubmitting the claim.

When correcting the claim to be resubmitted to CNFS the following steps should be taken.

1. Annotate “correction” on the top of the claim.
2. Include the batch number provided in the correction letter.
3. Be sure Box A is marked in Item 3. This would still be an original claim.
4. The claim must be completely filled out, no missing data.
5. Place zeros in spaces where data was previously reported and there is no change. (Day Care Homes claims are to have no blank spaces, all spaces not reporting data should be filled with zeros).
5. Claim must have an original signature and date.

Note: Corrections to a claim cannot be made by CNFS staff via telephone conversation. All claim corrections must be made by submitting an original signed corrected claim.

If a correction to your claim is required, payment will be delayed by at least three weeks. If a valid correction is not received by the requested date, no payment will be processed for the claim month.

Cash Advance

Public Law 104-193 allows State Agencies the option of offering advance payments to CACFP sponsors. Cash advance is a payment made in advance of claim reimbursement to improve cash flow. Advances are based on estimated monthly reimbursement; and a sponsor may choose to receive a full advance, partial advance, or no advance (CFR, Section 226.6(b)(10)).

Please note that advance funds are **not** start-up funds. Specifically, a cash advance is financial assistance made available to a sponsor for program costs prior to the month in which such costs will be incurred. Advance funds must be identified within the agency's accounting system as advance funds and noted as an "accounts payable". The advance must be paid back to CDE when an agency terminates the Agreement to Participate, chooses to discontinue the advance, or upon demand by USDA or CDE.

The State of California currently offers cash advance calculated on estimated meal reimbursement for child and adult care centers and estimated administrative reimbursement for family day care homes.

A sponsor may request a cash advance during initial application to participate in the CACFP or during the renewal process.

When NSD approves the application or renewal, an initial cash advance will be calculated based on the sponsor's budget and payment issued. Thereafter, the sponsor's cash advance will be adjusted based on actual reimbursement.

Meal Advance (Child and Adult Care Centers)

Meal cash advance is calculated using the current federal reimbursement, "rates times meals" (including cash-in-lieu). State meal reimbursement is not included in this advance. The advance is based on the number of meals served over a two-month period. This calculated advance is disbursed by CNFS in monthly increments.

For specifics related to sponsor disbursement of advance funds, please consult the Child and Adult Day Care Centers Administrative Manual or your field consultant.

Administrative Advance (Family Day Care Home Sponsors)

Administrative cash advance is based on estimated administrative reimbursement, "rates times homes". Administrative cash advance can only be used for CACFP administrative expenditures, and may be deposited in an interest-bearing account. Interest earned on advance funds is income to the program and must be spent for allowable administrative costs. In addition, the earned interest must be clearly identified in the sponsor's accounting system.

How the Cash Advance System Works

The CACFP payment system adjusts cash advance based on actual meal or administrative reimbursement. The three-month period prior to the advance adjustment is used to determine the average reimbursement for the period. The average reimbursement is multiplied by two, calculating the advance amount. The calculated advance amount is compared to the previous advance to determine if the sponsor's cash advance will be adjusted downward or upward or remain the same. Overpayments (downward adjustments) are deducted from the next available claims for reimbursement. Overpayment adjustments may cause a payment reduction of 50 to 100 percent dependent upon the amounts of the overpayment and reimbursement. If the sponsor terminates from the CACFP, the advance is offset from any outstanding claim reimbursements at 100 percent and any remaining balance is invoiced.

Zero Claim

To prevent miscalculation of cash advance, active sponsors who receive cash advance must submit a "Zero Claim" for each month of non-participation. A Zero Claim will allow the cash advance payment system to use a varied method of calculating any cash advance adjustment. Not submitting Zero Claims will adversely affect your cash advance calculation.

Cash Advance Cancellation

A sponsor may request to cancel their cash advance at any time. This request must be in the form of a letter stating that the cash advance is no longer desired. This letter should be addressed to the Nutrition Services Division, Resource and Information Management Unit (RIM) and state whether you wish to have the outstanding cash advance recovered incrementally or fully from future reimbursements.

If a sponsor is terminated or cancels participation in the CACFP, 100 percent of all reimbursements will be captured to offset any outstanding cash advance. If a balance remains after all claims have cleared, an invoice will be generated for the outstanding amount.

Administrative Reimbursement

FEDERAL REIMBURSEMENT

Day Care Homes

Day Care Home sponsors receive administrative reimbursement based on the lesser of four factors on a year to date basis:

1. Approved homes times USDA approved rates.
2. Actual costs of administering the program less income.
3. Amount of administrative costs approved by CDE in the annual budget.
4. USDA Calculation – Administrative costs may not exceed 30% annually of administrative and meal reimbursement payments.

Federal reimbursements for administrative costs are paid only to Day Care Homes.

STATE REIMBURSEMENT

Day Care Homes

State meal reimbursement is calculated using the current state rate multiplied by 75 percent of the total reimbursable breakfasts and lunches claimed. A sponsor may retain no more than 30 percent of the state meal reimbursement for administrative purposes.

Example: 1200 (b-fasts) + 1350 (lunches) = 2550 X .75 x .1324 = $253.22
$253.22 X .30 = $75.97 = maximum amount of state meal reimbursement sponsor may retain.

The balance is distributed to providers based on number of meals served.

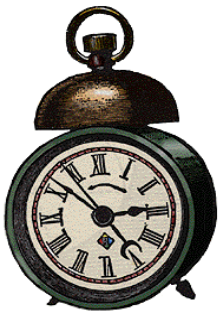
Child Care Centers

State meal reimbursement is calculated using the current state rate multiplied by the total number of free and reduced breakfasts and lunches served.

Adult Day Care Centers are not eligible for state meal reimbursement.

PAGE INTENTIONALLY LEFT BLANK

Appendix



CLAIM SUBMISSION DEADLINES

October 2003 through September 2004

Claim Month (Item 2)	**Submission Deadline** (Postal cancellation stamp)
October 2003	**Monday, Dec. 22, 2003**
November 2003	**Tuesday, Jan. 20, 2004**
December 2003	**Friday, Feb. 20, 2004**
January 2004	**Monday, March 22, 2004**
February 2004	**Tuesday, April 20, 2004**
March 2004	**Thursday, May 20, 2004**
April 2004	**Monday, June 21,2004**
May 2004	**Wednesday, July 21, 2004**
June 2004	**Friday, Aug. 20, 2004**
July 2004	**Monday, Sep. 20, 2004**
August 2004	**Wednesday, Oct. 20, 2004**
September 2004	**Monday, Nov. 22, 2004**

REIMBURSEMENT CLAIM CHECKLIST
Fixed Percentage Claiming Method

Please make the following checks of your claim prior to submitting it for reimbursement. **An error or omission in any of the following items will cause a delay in your reimbursement.**

REPORTING

( ) Item 1. Is a label affixed to the claim form? If you do not have a label, type or print your agreement number, name, and address in the space provided in item 1.

( ) 2. Is the month reported in item 2 the claim month, **not** the month the claim was prepared?

( ) 3. Is the correct box in item 3 checked?

( ) 6.and 8. Did you report sites and operating days? Your claim cannot be processed without this information. **Remember, you may only claim reimbursement for meals served at approved sites.**

( ) 7. Do you need to report program enrollment this month? Please refer to the Administrative Manual for detailed instructions.

( ) 9. Is the average daily participation rounded **up** to the next whole number? **Never round down your average daily participation.**

( ) 10. Did you report the meals served in the correct box?

AUDIT CHECKS

( ) The average daily participation reported in item 9 cannot be greater than the total enrollment reported in item 7.

( ) The number of breakfasts, lunches, or suppers cannot exceed the product of average daily participation multiplied by operating days.

( ) The number of supplements reported may not exceed two times the product of average daily participation multiplied by operating days. ***Note: Due to the elimination of the fourth meal service enacted by the Personal Responsibility and Work Opportunity Act of 1996, you may claim no more than two meals and one supplement or one meal and two supplements per child per day. After-School, At-Risk, and Homeless Sponsors may claim only one supplement per child per day.***

CERTIFICATION

( ) Is there an **original** signature of an authorized official on the claim? **Carbon, stamped, or photocopied signatures will not be accepted.**

GENERAL

( ) Is the claim typed or legibly printed?

( ) Did you remember to make a copy of your claim to submit with the claim form? Copies may be photocopied or carbon. Claims submitted without a copy will be returned unprocessed.

REIMBURSEMENT CLAIM CHECKLIST
Actual Count Claiming Method

Please make the following checks of your claim prior to submitting it for reimbursement. **An error or omission in any of the following items will cause a delay in your reimbursement.**

REPORTING

( ) Item 1. Is a label affixed to the claim form? If you do not have a label, did you type or print your agreement number, name, and address in the space provided in item 1.

( ) 2. Is the month reported in item 2 the claim month, **not** the month the claim was prepared?

( ) 3. Is the correct box in item 3 checked?

( ) 6,7,8. Did you report sites, enrollment by eligibility category, and operating days? Your claim cannot be processed without this information. **Remember, you may only claim reimbursement for meals served at approved sites.**

( ) 9. Is the average daily participation rounded **up** to the next whole number? **Never round down your average daily participation.**

AUDIT CHECKS

( ) The average daily participation reported in item 9 cannot be greater than the total enrollment in item 7.

( ) The sum of the free plus reduced price plus base rate meals must equal the total meals reported for each meal type.

( ) The number of breakfasts, lunches, or suppers cannot exceed the product of average daily participation multiplied by operating days.

( ) The number of supplements reported cannot exceed two times the product of average daily participation multiplied by operating days. ***Note: Due to the elimination of the fourth meal service enacted by the Personal Responsibility and Work Opportunity Act of 1996, you may claim no more than two meals and one supplement or one meal and two supplements per child per day. After-School, At-Risk, and Homeless Sponsors may claim only one supplement per child per day.***

CERTIFICATION

( ) Is there an **original** signature of an authorized official on the claim? **Carbon, stamped, or photocopied signatures will not be accepted.**

GENERAL

( ) Is the claim typed or legibly printed?

( ) Did you remember to make a copy of your claim to submit with the claim form? Copies may be photocopied or carbon. Claims submitted without a copy will be returned unprocessed.

REIMBURSEMENT CLAIM CHECKLIST
Day Care Homes

Please make the following checks of your claim prior to submitting it for reimbursement. **An error or omission in any of the following items will cause a delay in your reimbursement.**

REPORTING

( ) Item 1.* Is a label affixed to the claim form? If you do not have a label, type or print your agreement number, name, and address in the space provided in item 1.

( ) 2.* Is the month reported in item 2 the claim month, **not** the month the claim was prepared?

( ) 3.* Is the correct box in item 3 checked?

( ) 6.* <u>Did you report operating days</u> in the box provided to the far right of item 6?

( ) 7.* Did you report sites by tiering category? Sum across to equal total sites.
Remember, you may only claim reimbursement for meals served at approved sites.

( ) 8.* Did you report your average daily participation by site tiering category? Sum across to equal total average daily participation. Round the average daily participation **up** to the nearest whole number? **Never round down for average daily participation.**

( ) 9.* Did you report your enrollment by the correct tiering category as it relates to each tiering meal category? Remember to add together the Tier II High enrollment and the Tier II Mixed children approved for Tier I reimbursement. Likewise add the Tier II Low enrollment and the Tier II Mixed children approved for Tier II reimbursement. Sum across to equal total enrollment.

( ) 10. Did you report meals by the correct meal type using the correct tiering meal category? Sum across to equal meal type totals.

( ) 11.* Did you report administrative expenses? Report whole dollars only.

( ) 12. If state reimbursement is retained for administrative expenses, is it reported in item 12?

* **Your claim cannot be processed without these items.**

AUDIT CHECKS

( ) The total sites reported cannot exceed the sum of Tier I, Tier II High, Tier II Low and Tier II Mixed sites.

( ) The ***Tier I, Tier II High, Tier II Low or Total Average Daily Participation*** reported in item 8 cannot be greater than the ***Tier I, Tier II High, Tier II Low or Total Enrollment*** reported in item 9.

( ) The number of tiering breakfasts, lunches, **or** suppers reported cannot exceed the product of tiering enrollment type multiplied by operating days. *i.e. The number of Tier I Breakfasts, Lunches **or** Suppers must be less than or equal to the product of Tier I Enrollment times Operating Days. Likewise for Tier II High, Tier II Low **and** Total Breakfasts, Lunches **or** Suppers.*

( ) The number of tiering supplements reported cannot exceed two times the product of tiering enrollment multiplied by operating days. *i.e. Tier I enrollment times operating days cannot exceed two times Tier I Supplements. Likewise for Tier II High, Tier II Low and Total Supplements.*

CERTIFICATION

( ) Is there an **original** signature of an authorized official on the claim? **Carbon, stamped, or xeroxed signatures will not be accepted.**

GENERAL

( ) Is the claim typed or legibly printed?

( ) Did you remember to make a copy of your claim to submit with the original? The copy may be a xerox or carbon copy. Claims submitted without a copy will be returned unprocessed.

MONTHLY REIMBURSEMENT CALCULATION WORKSHEET
CHILD and ADULT CARE FOOD PROGRAM
Fixed Percentage Claiming Method

Use rates applicable to claim year. Month ____ Year ____

To compute the fixed percentages, enter the number of participants reported in each eligibility category in Item 7 of the claim form on the lines below:

Free	Reduced Price	Base Rate	Total Enrollment

Next, convert these numbers in each eligibility category to percentages by individually dividing the number of free, reduced price, and base rate participants by the total enrollment. Carry the percentages to **4 decimal places**.

(A)_____ % Free (B)_____ % Reduced Price (C)_____ % Base Rate

To compute the **Federal Reimbursement** for meals served by meal type and eligibility category, multiply the percentages computed above for each eligibility category by the total meals served for each meal type, rounding the computed meals to the nearest whole number. Then multiply these computed meals by the federal reimbursement rate utilizing the table below:

(1) BREAKFAST TOTAL _____ (Item 10 of the claim form)

BREAKFAST TOTAL		CALCULATED PERCENTAGE		CALCULATED MEALS		BREAKFAST RATE		REIMBURSEMENT
	X	% FREE (A)	=	FREE MEALS (1a)	X	$ FREE	=	$
	X	% REDUCED (B)	=	REDUCED MEALS (1b)	X	$ REDUCED	=	$
	X	% BASE (C)	=	BASE MEALS (1c)	X	$ BASE	=	$

(2) LUNCH TOTAL _____ (Item 10 of the claim form)

LUNCH TOTAL		CALCULATED PERCENTAGE		CALCULATED MEALS		LUNCH RATE		REIMBURSEMENT
	X	% FREE (A)	=	FREE MEALS (2a)	X	$ FREE	=	$
	X	% REDUCED (B)	=	REDUCED MEALS (2b)	X	$ REDUCED	=	$
	X	% BASE (C)	=	BASE MEALS (2c)	X	$ BASE	=	$

(3) SUPPER TOTAL _____ (Item 10 of the claim form)

SUPPER TOTAL		CALCULATED PERCENTAGE		CALCULATED MEALS		SUPPER RATE		REIMBURSEMENT
	X	% FREE (A)	=	FREE MEALS (3a)	X	$ FREE	=	$
	X	% REDUCED (B)	=	REDUCED MEALS (3b)	X	$ REDUCED	=	$
	X	% BASE (C)	=	BASE MEALS (3c)	X	$ BASE	=	$

(4) SUPPLEMENT TOTAL _____ (Item 10 of the claim form)

SUPPLEMENT TOTAL		CALCULATED PERCENTAGE		CALCULATED MEALS		SUPPLEMENT RATE		REIMBURSEMENT
	X	% FREE (A)	=	FREE MEALS (4a)	X	$ FREE	=	$
	X	% REDUCED (B)	=	REDUCED MEALS (4b)	X	$ REDUCED	=	$
	X	% BASE (C)	=	BASE MEALS (4c)	X	$ BASE	=	$

Total Federal Reimbursement for Meals $_____

To compute the **Federal Reimbursement** for Cash-In-Lieu of commodities, multiply the total number of Lunches (2) and Suppers (3) served by the reimbursement rate:

Lunches (2) _____ + Suppers (3) _____ = _____ X $_____ = $_____

To compute the **State Reimbursement**, multiply the number of free and reduced price Breakfasts and Lunches served by the state reimbursement rate:

Free and Reduced Price Breakfasts and Lunches (1a+1b+2a+2b) _____ X $_____ = $_____

MONTHLY REIMBURSEMENT CALCULATION WORKSHEET
CHILD and ADULT CARE FOOD PROGRAM
Actual Count Claiming Method

Use rates applicable to claim year. Month _____ Year _____

==========

To compute the **Federal Reimbursement** for meals by meal type, multiply the meals served (Item 10 of the claim form) by the federal reimbursement rates:

(1) BREAKFAST TOTAL ____ ____

BREAKFAST MEALS		RATE			REIMBURSEMENT
FREE (1a)	X	$	FREE	=	$
REDUCED (1b)	X	$	REDUCED	=	$
BASE (1c)	X	$	BASE	=	$

(2) LUNCH TOTAL _____

LUNCH MEALS		RATE			REIMBURSEMENT
FREE (2a)	X	$	FREE	=	$
REDUCED (2b)	X	$	REDUCED	=	$
BASE (2c)	X	$	BASE	=	$

(3) SUPPER TOTAL _____

SUPPER MEALS		RATE			REIMBURSEMENT
FREE (3a)	X	$	FREE	=	$
REDUCED (3b)	X	$	REDUCED	=	$
BASE (3c)	X	$	BASE	=	$

(4) SUPPLEMENT TOTAL _____

SUPPLEMENT MEALS		RATE			REIMBURSEMENT
FREE (4a)	X	$	FREE	=	$
REDUCED (4b)	X	$	REDUCED	=	$
BASE (4c)	X	$	BASE	=	$

Total Federal Reimbursement for meals = $_____

To compute **Federal Reimbursement** for Cash-In-Lieu, multiply total Lunches (2) plus total Suppers (3) by the reimbursement rate:

Lunches (2) _____ + Suppers (3) _____ = _____ X $____ = $_____

==========

To compute **State Reimbursement**, multiply the number of free and reduced price Breakfasts and Lunches served by the state reimbursement rate:

Free and Reduced Price Breakfasts and Lunches (1a+1b+2a+2b) _____ X $_____ = $_____

MONTHLY REIMBURSEMENT CALCULATION WORKSHEET
CHILD and ADULT CARE FOOD PROGRAM
Sponsors of Independent Centers using the Actual Count Claiming Method

Use rates applicable to claim year. Month _____ Year _____

==========

To compute the **Federal Reimbursement** for meals by meal type, multiply the meals served (Item 10 of the claim form) by the federal reimbursement rates:

(1) BREAKFAST TOTAL _____

BREAKFAST MEALS		RATE			REIMBURSEMENT
FREE (1a)	X	$	FREE	=	$
REDUCED (1b)	X	$	REDUCED	=	$
BASE (1c)	X	$	BASE	=	$

(2) LUNCH TOTAL _____

LUNCH MEALS		RATE			REIMBURSEMENT
FREE (2a)	X	$	FREE	=	$
REDUCED (2b)	X	$	REDUCED	=	$
BASE (2c)	X	$	BASE	=	$

(3) SUPPER TOTAL _____

SUPPER MEALS		RATE			REIMBURSEMENT
FREE (3a)	X	$	FREE	=	$
REDUCED (3b)	X	$	REDUCED	=	$
BASE (3c)	X	$	BASE	=	$

(4) SUPPLEMENT TOTAL _____

SUPPLEMENT MEALS		RATE			REIMBURSEMENT
FREE (4a)	X	$	FREE	=	$
REDUCED (4b)	X	$	REDUCED	=	$
BASE (4c)	X	$	BASE	=	$

Total Federal Reimbursement for meals = $_____

To compute **Federal Reimbursement** for Cash-In-Lieu, multiply the total Lunches (2) plus total Suppers (3) by the reimbursement rate:

Lunches (2) _____ + Suppers (3) _____ = _____ X $____ = $_____

==========

To compute the **State Reimbursement**, multiply the number of free and reduced price Breakfasts and Lunches served by the state reimbursement rate:
Free and Reduced Price Breakfasts and Lunches (1a+1b+2a+2b) _____ X $____ = $_____

MONTHLY REIMBURSEMENT CALCULATION WORKSHEET
CHILD and ADULT CARE FOOD PROGRAM
DAY CARE HOMES

Use rates applicable to claim year. Month _____ Year _____

==========

To compute the **Federal Reimbursement** for meals by meal type, multiply the meals served (Item 10 of the claim form) by the federal reimbursement rate:

TIER I MEALS

TIER I MEALS		TIER I RATES		REIMBURSEMENT
BREAKFASTS (1)	X	$	=	$
LUNCHES (2)	X	$	=	$
SUPPERS	X	$	=	$
SUPPLEMENTS	X	$	=	$

Total Federal Tier I Reimbursement for Meals = $_____

TIER II HIGH MEALS

TIER II HIGH MEALS		TIER II HIGH RATES		REIMBURSEMENT
BREAKFASTS (1)	X	$	=	$
LUNCHES (2)	X	$	=	$
SUPPERS	X	$	=	$
SUPPLEMENTS	X	$	=	$

Total Federal Tier II High Reimbursement for Meals = $_____

TIER II LOW MEALS

TIER II LOW MEALS		TIER II LOW RATES		REIMBURSEMENT
BREAKFASTS (1)	X	$	=	$
LUNCHES (2)	X	$	=	$
SUPPERS	X	$	=	$
SUPPLEMENTS	X	$	=	$

Total Federal Tier II Low Reimbursement for Meals = $ _____

Total Federal Reimbursement for Meals = $ _____

==========

To compute the **State Reimbursement** for meals, add the total number of Breakfasts (1) for all tiers and Lunches (2) for all tiers, multiply by 75%, then multiply by the state reimbursement rate:

Breakfasts (1) + Lunches (2) = _____ X 0.75 = _____ X $_____ = $_____

Corrective Action Plan to Accompany a Request for Payment For a Late Claim for Child Nutrition Reimbursement Under the One-Time Exception Category

Please type or print Information or affix label	Agreement No: Sponsor Name: Sponsor Address:

Child Nutrition Program: (check one)

- ☐ **Child Care Food Program**
- ☐ **Adult Day Care Food Program**
- ☐ **School Nutrition Program**
- ☐ **Summer Food Service Program**

Month/Year of Late Claim: ..... /

1. **Explain in detail the problem(s), which contributed to the claim being late. (Use additional page if needed.)**

2. **Detail the actions you are taking to avoid a late claim in the future. (Use additional page if needed.)**

Sponsor Certification: By signing this form below we understand that this one-time request will be granted only if this Corrective Action Plan is approved by NSD, and that only one late claim can be granted under this one-time category every three years.

Signatures

Person Responsible for completing and submitting claims each month.	**Person who signed the Agreement with NSD to operate the Child Nutrition Program.**
Signature:	**Signature:**
Print Name:	**Print Name:**
Date:	**Date:**
Phone:	**Phone:**

California Department of Education
Fiscal & Administrative Services Division
Form CACFP-F (Rev. 10-2001)

RETURN TO:

California Department of Education
Fiscal & Administrative Services Division
P.O. Box 587
Sacramento, CA 95812-0587

CLAIM FOR REIMBURSEMENT
CHILD AND ADULT CARE FOOD PROGRAM
Fixed Percentage Claiming Method

Note: Please submit an original and one copy of the claim by the claim submission target date of the 10th of the month following the month claimed. In addition, all claims (original, adjusted, or corrected) must be postmarked by the 20th day of the second month following the month claimed in order to be considered for payment.

All claims must be submitted with a copy. Retain a copy for your files.

1. Affix mailing label in space provided below. (If label is not available, fill in sponsor's agreement number, name and address.)

Agreement Number

2. Month covered by report — Month / Year

3. ☐ A. This is an original claim.
☐ This is an adjusted claim.
No subsequent claim will be submitted for this month.

For State use only

4. Adjustment Number — Reason Code

6. Number of approved sites for approved this month……

7. Program Enrollment (See instructions in Administrative Manual before completing this item)	Number of participants eligible for reduced price meals	Number of participants eligible for free meals	Number of participants for base rate meals	Total

8. Number of days served meals were served this month……..

9. Average daily participation (rounded up the next whole number)……..

10. Meals Served

Breakfast …….. Breakfast	
Lunch…… Lunch	
Supper …….. Dinner	
Supplements…… Snack	

I certify that to the best of my knowledge and belief this claim is true and correct in all respects; that records are available to support this claim; that it is in accordance with the terms of existing agreement(s); and that I have not received payment for this claim.

Name of claim preparer (Please print)	Telephone number of claim preparer EXTENSION ( ) ( )	Date
Signature of authorized official	Name of authorized official	Title of authorized official

California Department of Education
Fiscal & Administrative Services Division
Form CACFP-A (Rev. 10-2001)

RETURN TO:

California Department of Education
Fiscal & Administrative Services Division
P.O. Box 587
Sacramento, CA 95812-0587

CLAIM FOR REIMBURSEMENT
CHILD AND ADULT CARE FOOD PROGRAM
Actual Count Claiming Method

Note: Please submit an original and one copy of the claim by the claim submission target date of the 10th of the month following the month claimed. In addition, all claims (original, adjusted, or corrected) must be postmarked by the 20th day of the second month following the month claimed in order to be considered for payment.

All claims must be submitted with a copy. Retain a copy for your files.

1. Affix mailing label in space provided below. (If label is not available, fill in sponsor's agreement number, name and address.)

Agreement Number

2. Month covered by report — Month | Year

3. ☐ A. This is an original claim.
☐ B. This is an adjusted claim.
☐ No reimbursement will be claimed this month.

FEMA & State use only

4. Adjustment Number 5. Reason Code

6. Number of approved sites that operated during this month……

7. Program Enrollment (See instructions in Administration Manual before completing this item)	Number of participants eligible for free meals	Number of participants eligible for reduced price meals	Number of participants eligible for base rate meals	Total

8. Number of approved sites where served this month……..

9. Average daily participation (rounded up to the next whole number)……..

10. Meals Served	Free	Reduced Price	Base	Total
Breakfast				
Lunch				
Supper				
Supplements				

I certify that to the best of my knowledge and belief this claim is true and correct in all respects; that records are available to support this claim; that it is in accordance with the terms of existing agreement(s); and that I have not received payment for this claim.

Name of claim preparer (Please print)	Telephone number of claim preparer EXTENSION ( ) ( )	Date
Signature of authorized official	Name of authorized official (Please print)	Title of authorized official

California Department of Education
Fiscal & Administrative Services Division
Form CACFP-I (Rev. 10-2001)

RETURN TO:

California Department of Education
Fiscal & Administrative Services Division
P.O. Box 587
Sacramento, CA 95812-0587

CLAIM FOR REIMBURSEMENT
CHILD AND ADULT CARE FOOD PROGRAM
Actual Count Claiming Method
for Sponsors of Independent Centers

Note: Please submit an original and one copy of the claim by the claim submission target date of the 10th of the month following the month claimed. In addition, all claims (original, adjusted, or corrected) must be postmarked by the 20th day of the second month following the month claimed in order to be considered for payment.

All claims must be submitted with a copy. Retain a copy for your files.

1. Affix mailing label in space provided below. (If label is not available, fill in sponsor's agreement number, name and address.)

Agreement Number

2. Month covered by report — Month | Year

3. ☐ A. This is an original claim.
☐ B. This is an adjusted claim.
☐ C. No reimbursement was claimed this month.

ITEMS 4 & 5 For State use only
4. Agreement number 5. Reason code

6. Number of approved sites that operated during this month……

7. Program Enrollment (See instructions in Administrative Manual before completing this item)	Number of participants eligible for free meals	Number of participants eligible for reduced price meals	Number of participants eligible for paid meals	Total

8. Number of days program meals were served this month……

9. Average daily participation (rounded up to the next whole number)……

10. Meals served

	Free	Reduced Price	Base	Total
Breakfast				
Lunch				
Supper				
Supplements				

11. CCFP administrative expenses for this month. (Round to the nearest dollar, do not report cents)…… $

12. CCFP administrative income for this month. (Rounded to the nearest dollar, do not report cents)…… $

I certify that to the best of my knowledge and belief this claim is true and correct in all respects; that records are available to support this claim; that it is in accordance with the terms of existing agreement(s); and that I have not received payment for this claim.

Name of claim preparer (Please print)	Telephone number of claim preparer EXTENSION ( ) ( )	Date
Signature of authorized official	Name of authorized official (Please print)	Title of authorized official

California Department of Education
Fiscal & Administrative Services Division
Form CACFP-T2 (Rev. 10-2001)

RETURN TO:

California Department of Education
Fiscal & Administrative Services Division
P.O. Box 587
Sacramento, CA 95812-0587

CLAIM FOR REIMBURSEMENT
CHILD CARE FOOD PROGRAM
Day Care Homes

Note: Please submit an original and one copy of the claim by the claim submission target date of the 10th of the month following the month claimed. In addition, all claims (original, adjusted, or corrected) must be postmarked by the 20th day of the second month following the month claimed in order to be considered for payment.

All claims must be submitted with a copy. Retain a copy for your files.

1. Affix mailing label in space provided below. (If label is not available, fill in sponsor's agreement number, name and address.)

Agreement Number ☐☐–☐☐☐☐–☐–☐

2. Month covered by report — Month | Year

3. ☐ A. This is an original claim.
☐ B. This is an adjusted claim.
☐ C. No reimbursement will be claimed this month.

ITEM 4 [illegible] 5 [illegible] State Use Only

4. Adjustme[illegible] Num[illegible]

5. Re[illegible]n Code

6. Number of **DAYS** program meals were served this mon[illegible]…>…[illegible]…>…[illegible]…>…[illegible]…>…[illegible]…>…

	Tier I	Tier II High	Tier II [illegible]	[illegible]er Mixed	Total
7. Approved **SITES** that c[illegible]ate[illegible]s [illegible]nt					
8. Ave[illegible] Daily [illegible]rticipa[illegible] (R[illegible]de up					

	[illegible]r I Enro[illegible]ent	Tier I[illegible]roll	Tie[illegible] Low Enroll	Total Enrollment
9. Pr[illegible]ram Enro[illegible]t ….				

	[illegible]r	Tier II High	Tier II Low	Total Meals
10. M[illegible] erv[illegible] kfa[illegible]				
L[illegible]ch……				
[illegible]pp[illegible]……..				
Supplements……..				

11. CCFP administrative expenses for this month. (Rounded to the nearest dollar)	**$**
12. CCFP administrative income for this month. (Rounded to the nearest dollar)	**$**

I certify that to the best of my knowledge and belief this claim is true and correct in all respects; that records are available to support this claim; that it is in accordance with the terms of existing agreement(s); and that I have not received payment for this claim.

Name of claim preparer (Please print)	Telephone number of claim preparer EXT ( )	Date
Signature of authorized official	Name of authorized official (Please print)	Title of authorized official